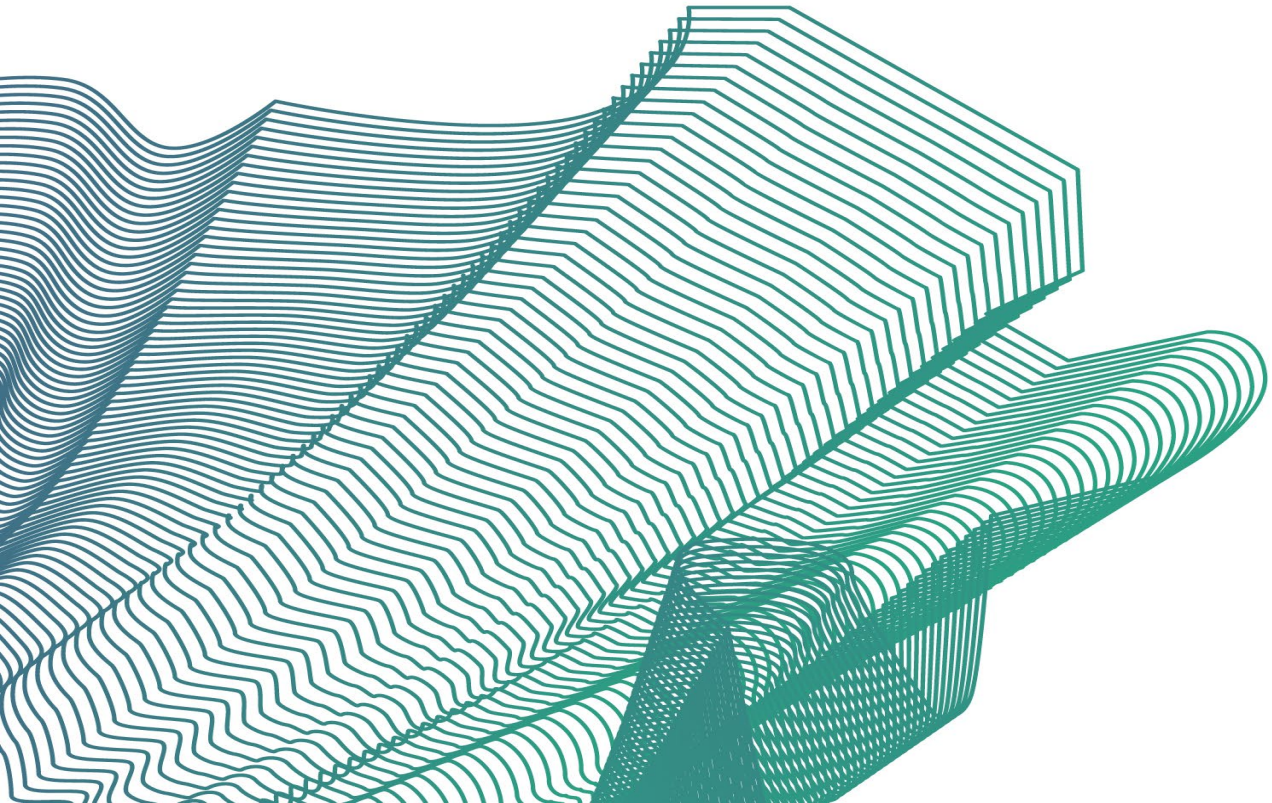
ROTHERHAM
INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

Rotherham Winter Plan 2026/27

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NHS
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Clinical Commissioning Group
Rotherham, Doncaster
and South Humber
NHS Foundation Trust
The Rotherham
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Introduction

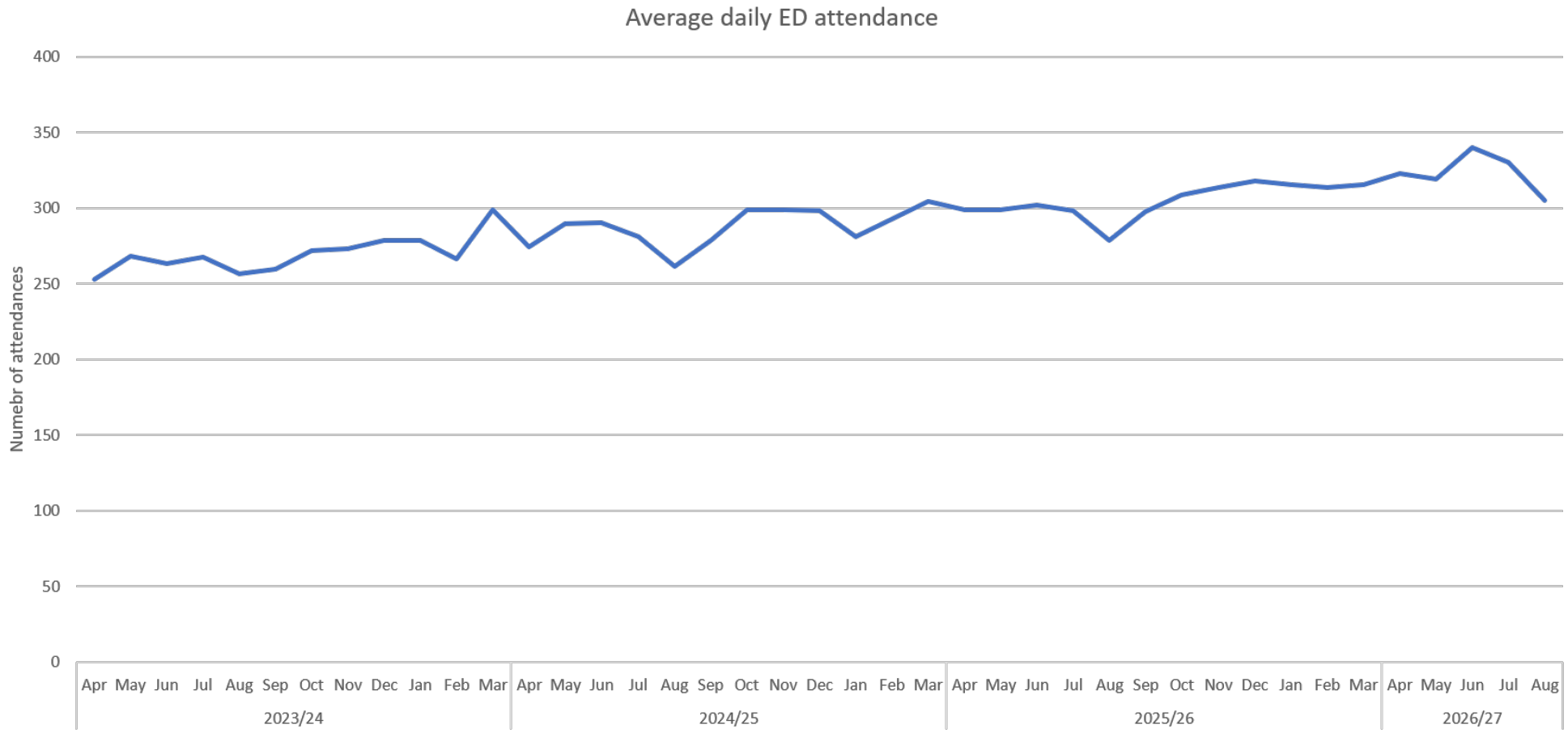
- Winter 2025-26
- Lessons Learned
- Plans for Winter 2026-27
- Risks and Issues
- Glossary

Winter 2025/26 Summary

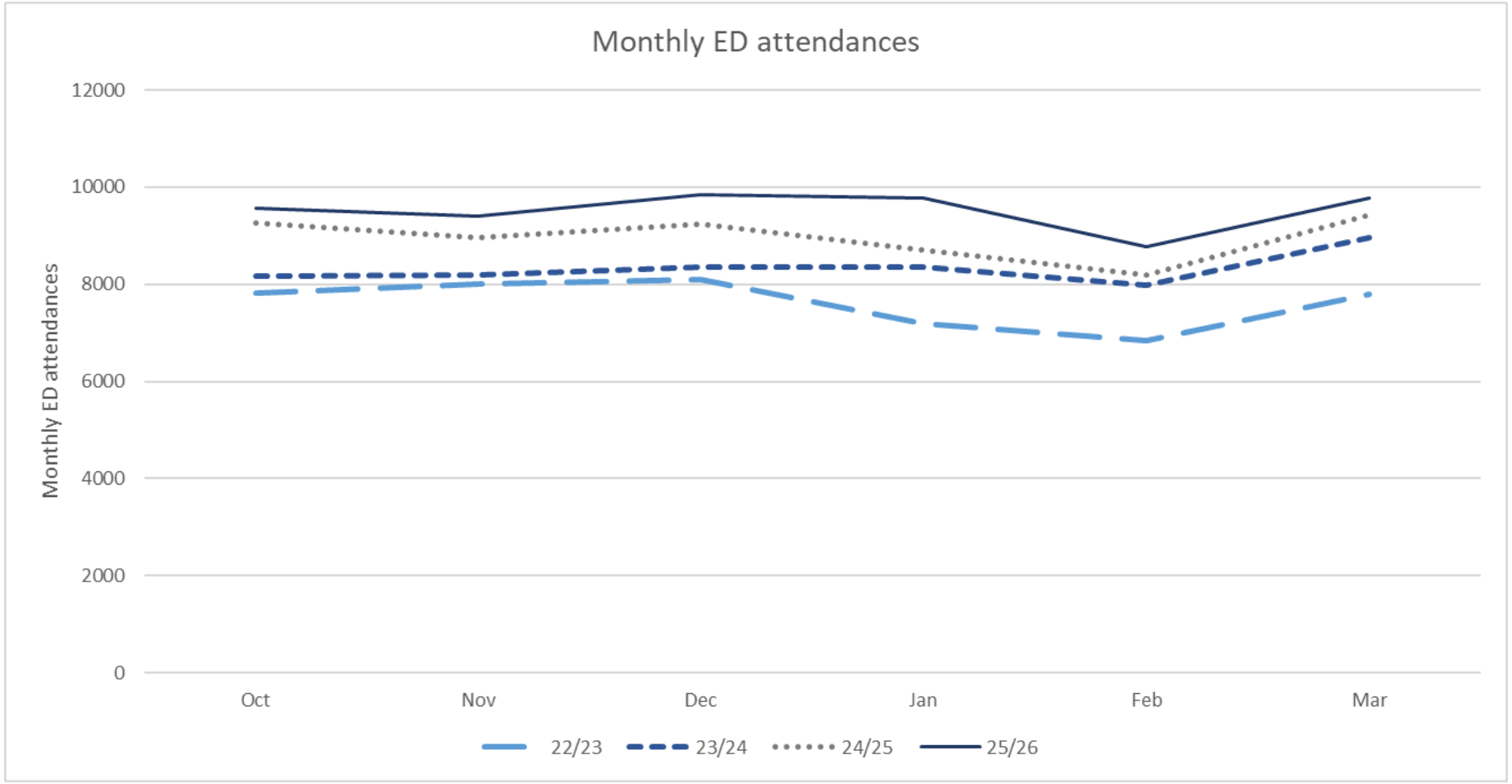


- Despite extensive development of admission avoidance pathways and activity to improve system flow, we have seen unprecedented levels of demand in the Emergency Department (ED)
- The average number of daily attendances was 314 through October to March. We saw the highest ever daily attendance of 412 on 27 April, which was subsequently exceeded with 432 on 29 June.
- ED attendance winter 25/26 was up 6% Oct-Mar compared to the same period 24/25; January 2026 attendances were 12% higher than last year
- This trend is not isolated to Rotherham – demand is up nationally
- Evidence shows that, despite the increased demand, we are managing these increased pressures more effectively as a system.
- 4-hour performance was lower than target throughout much of winter but was 5-8 percentage points higher that the same period 24/25
- In addition, ambulance handover times show a marked improvement of 25% in April 2025/26 compared to compared with April 2024 (18.62 minutes to 14.10 minutes)

Demand for Urgent Care



Winter increases



Lessons learned

Mental Health

Early workforce planning enabled proactive staffing re-views and robust bank holiday cover arrangements.



Social Care

Deployment of additional social worker capacity and ward-based Enablement assessments improved patient flow and service capacity.



Acute

Enhancing the interface between acute and community; development of D2A offer; review of capacity and demand in out of hospital pathways.



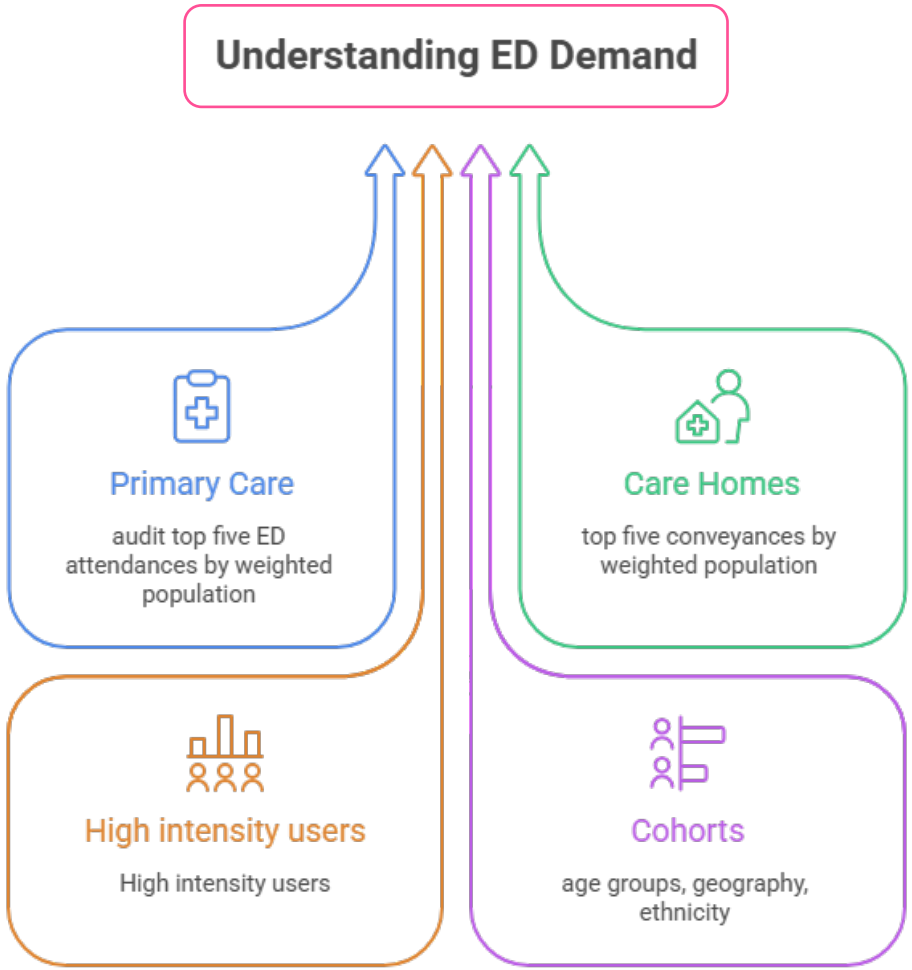
Going into this winter…

- High levels of demand throughout summer – record daily high seen in June
- New ED attendance ‘normal’ level of 320+ daily attendances puts pressure on system flow and discharge pathways
- Increased summer demand reflects a national trend
- 4-hour performance, ambulance handover, and ambulance response times have improved
- Higher levels of complexity & acuity have increased pressure on discharge pathways requiring higher levels of care
- Operational refinements and increased capacity in enablement has seen an increase in contact time
- High intensity user pathway pilot in place



Response to increased demand

- Analysis of ED activity, population demographics, patient insight data and relevant evidence undertaken
- Some underlying drivers of demand and key areas of focus identified
- Focus on prevention, admission avoidance, increasing utilisation of ED alternatives, and addressing the root causes of high-frequency attendance to prevent avoidable presentations and improve patient outcomes



Rotherham Winter Plan

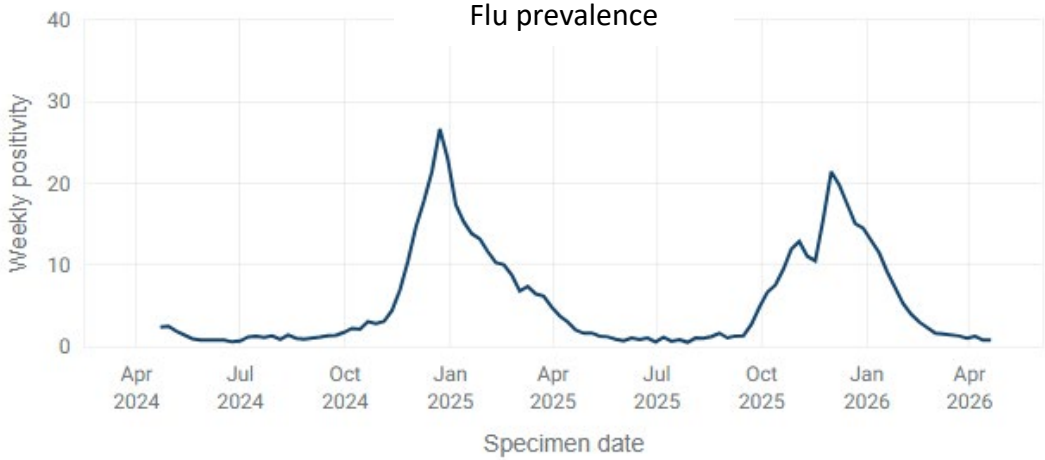
The Rotherham winter plan is designed to support responses to increased demand, provide resilience at times of peak pressure, and deliver against national priorities



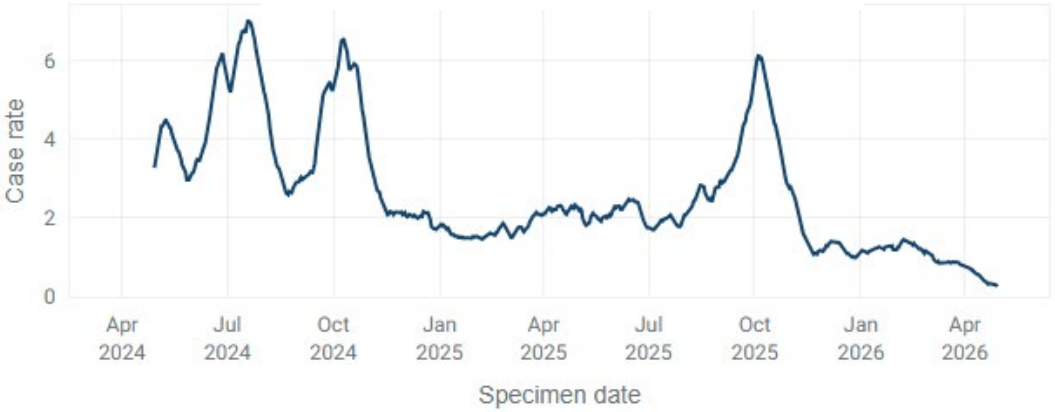
Vaccination

- 2025/26 saw earlier flu onset but lower peak compared to 2024/25
- Flu onset coincided with COVID autumn peak resulting in early pressure in ED
- Retaining the main adult rollout start date of 1 October for 2026/27 balances early seasonal circulation risks against evidence of vaccine effectiveness waning too early if administered ahead of December/January peaks
- Pharmacy Childhood Service for 2–3-year-olds expanded to include clinically at-risk children aged 2-17
- Targeted engagement with care home residents and staff, with work underway to identify and address barriers to vaccination for care home staff
- Flexible staff vaccination offers in place across TRFT, RMBC, and RDaSH to support winter resilience

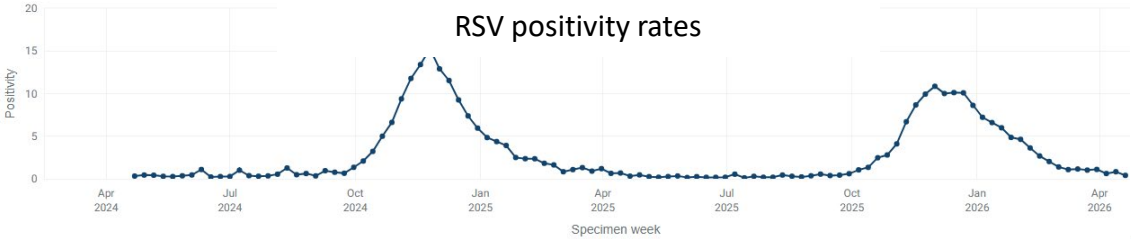
Flu prevalence



COVID rates



RSV positivity rates



National Priorities 2026/27

Target	Rotherham Actions
A&E performance: At least 82% of A&E patients to be admitted, transferred, or discharged within 4 hours by March 2027	• Increased utilisation of community pathways including Hospital at Home as alternatives to ED • ARI Hub providing additional 7-day capacity to support primary care with respiratory assessment and treatment . • New Acute Frailty Unit enabling quicker assessment and onward referral. • Additional winter beds and TES capacity. • Senior decision makers at the front door and rapid assessment processes in ED. • Earlier senior clinical assessment and daily consultant-led board rounds. • Focus on reducing long-stay patients and increasing discharge on the discharge-ready date.
Ambulance standards: Category 2 response times to average ≤ 30 minutes; handover times must not exceed 45 minutes	• Closer working between YAS and UCR with increased utilisation of ‘Push’ and ‘Pull’ pathways • CRES support for vulnerable respiratory patients. • Improved patient flow and discharge initiatives.
12-hour waits: Reduce instances of patients waiting over 12 hours in A&E to under 10% of cases (total time in dept)	• Executive review of longest delays. • Senior clinical decision makers and rapid assessment at the front door

National Priorities 2026/27

Target	Rotherham Actions
Discharge delays: Tackle patients delayed over 21 days, 14 days and 7 days	• Proactive management of all 7-, 14- and 21-day patients. • Executive review of longest delays. • Expanded CRU operating with Sunday opening and extended Saturday hours. • Additional pharmacy technician to support discharge medication. • Extended patient transport weekday and weekend operating hours • Increased Hospital at Home and step-down capacity. • RDaSH discharge coordinators, 15+ day reviews and clinically ready for discharge meetings. • ARI Hub to support admission avoidance • Strengthened TOCH model to reduce duplication and enable quicker decision-making • Improvements to the quality of referral information to support timely decision-making and reduce avoidable delays • Revision of Place escalation process to strengthen the system-wide response and support rapid discharge during periods of high demand.
Mental health waits: Eliminate waits over 12 hours for mental health patients in A&E	• 24/7 Crisis Resolution and Home Treatment Teams. • All-age crisis lines operating throughout winter. • One-hour response standard for emergency referrals. • Improved support for frequent attenders and high-intensity users. • 24/7 mental health patient flow oversight.

National Priorities 2026/27

Target	Rotherham Actions
Paediatric care: Increase children seen within 4 hours	• Planning for predictable paediatric demand peaks in October with additional Paediatric nurse 12 hours a day 7 days a week Oct-Jan • Community childhood vaccination activity
Elective waiting: At least 65% of patients waiting < 18 weeks by March 2026, and a 5-percentage point improvement across trusts	• Protection of elective activity remains a core winter planning principle. • Additional outpatient and theatre activity before and after winter peaks. • Dedicated elective orthopaedic capacity. • Use of day-case pathways to reduce dependency on inpatient beds. • Flow and discharge initiatives designed to protect elective beds. • Admission avoidance measures reducing pressure on inpatient capacity
Cancer targets: 75% for 62-day and 80% faster diagnosis by March 2026	• Explicit commitment to protect urgent cancer pathways during winter. • Protection of cancer diagnostics and diagnostic capacity. • Additional elective activity before and after periods of peak pressure. • Reduced dependence on inpatient beds through day-case pathways. • Whole-system flow initiatives helping maintain diagnostic and treatment capacity.

Risks and Issues (1)

Area	Risk description	Anticipated impact	Mitigation
Front door demand	• Higher than forecast emergency demand, particularly from respiratory illnesses. • Sustained pressure on ED, inpatient beds and urgent care services. • Seasonal surges exceeding planned capacity.	• System flow is compromised leading to patients facing longer waits for treatment and admission • Impact on performance measures including 4-hour standard and ambulance waiting times	• Additional escalation capacity including Sitwell Ward, TES beds and medical outlier capacity. • Expansion of admission avoidance services including Hospital at Home, SDEC and the ARI Hub. • Additional beds across commissioned bed-base to support surge capacity for IMC • Daily operational command structures, OPEL escalation processes and SCC oversight. • Targeted vaccination programmes for staff and vulnerable populations
System flow	Delayed discharges and transfers of care	• Increased occupancy and reduced acute capacity. • Increased numbers of patients with NCTR • Pressure on discharge pathways and community services	• Expansion of the Community Ready Unit (CRU), including Sunday opening, extended weekend hours and additional capacity • Additional pharmacy support and patient transport capacity. • Improved discharge tracking, strengthened Transfer of Care Hub arrangements and escalation meetings. • Focus on reducing long stays and increasing discharge on the discharge-ready date. • Community IMC capacity will be redirected to support flow from the hospital • Home from hospital will continue to operate to provide a level of bridging support. • Practitioner capacity will be flexibly deployed to increase bed base IMC and to support in assessing cases in TOCH, as appropriate

Risks and Issues (2)

Area	Risk description	Anticipated impact	Mitigation
Workforce resilience	• Increased staff sickness due to winter viruses. • Workforce pressures affecting service resilience. • Staffing challenges within specialist services, particularly mental health liaison psychiatry.	• Reduced staffing levels and service capacity during periods of peak demand • Increased pressure on remaining staff and heightened risk of workforce burnout • Delays to assessment, treatment, and discharge • Increased use of bank and agency staff, with associated cost pressures. • Reduced ability to deliver escalation capacity and maintain performance standards. • Delays in mental health assessments and increased length of stay for patients awaiting liaison psychiatry input	• Extensive staff flu vaccination programmes across organisations. • Workforce contingency planning, redeployment and bank staffing arrangements. • Health and wellbeing support programmes. • Flexible cross-cover arrangements and escalation routes. • Flexible deployment of the workforce to key pressure areas and step-down of non-critical activities to strengthen wellbeing and resilience.
Capacity	Insufficient capacity in community pathways and services unable to absorb discharge demand.	• Delays leading to pressure on acute beds, compromised system flow, and increased front door pressures. • Impact on patient experience and performance measures	• Improved care co-ordination • Planned growth in Hospital at Home activity & remote monitoring capability. • Capacity & demand reviews across discharge pathways to increase contact time. • Overflow beds, into other care home footprints, can be opened at the direction of the ICB and RMBC for wider surge capacity if needed • Development of integrated intermediate care and discharge-to-assess arrangements. • Commissioning colleagues are leading discussions with the independent care sector to ensure sufficient capacity and flow during peak winter periods, including care homes and domiciliary care provision

Risks and Issues (3)

Area	Risk description	Anticipated impact	Mitigation
Mental Health	• Increased staff sickness due to winter viruses. • Workforce pressures affecting service resilience. • Staffing challenges within specialist services, particularly mental health liaison psychiatry.	• Delays accessing inpatient mental health beds. • Mental health crisis bed pressures. • Delays in Mental Health Act assessments and Section 136 pathways. • Availability of Section 12 doctors and medical staffing challenges.	• 24/7 Patient Flow Teams and discharge coordination. • Mutual aid arrangements with neighbouring mental health providers. • Crisis alternatives including Safe Space, crisis lines and community-based support. • Strengthened multi-agency management of high-risk patients and frequent attenders.
Winter Vaccination	Low vaccination uptake among some staff groups and vulnerable cohorts, particularly care home staff. .	Greater risk of respiratory outbreaks and workforce absence	• Targeted vaccination comms and messaging • Engagement with lower-performing practices and care homes. • Outreach vaccination services. • Population health data utilised to target vulnerable and underserved groups
System Dependencies and Coordination	Reliance on primary care, social care, mental health services, community providers, Yorkshire Ambulance Service and wider partners.	Problems in any part of the system could adversely impact patient flow and resilience.	• Place-based escalation arrangements. • South Yorkshire SCC oversight and mutual aid processes. • Agreed OPEL action cards and escalation routes. • Regular operational meetings and system-wide intelligence sharing

Acronyms/Glossary

ARI hub: Acute Respiratory Infection Hub

CRES: Community Respiratory Exacerbation Service

CRU: Community Ready Unit

ED: Emergency Department

D2A: Discharge to Assess

ICB: Integrated Care Board

IMC: Intermediate Care

KLOEs: Key Lines of Enquiry

NCTR: No criteria to reside

OPEL: Operational Pressures Escalation Levels

RDASH: Rotherham, Doncaster and South Humber NHS Foundation Trust

RMBC: Rotherham Metropolitan Borough Council

SCC: System Coordination Centre

Section 12: Section 12 of the Mental Health Act 1983 requires two medical recommendations for a person's compulsory hospital admission or guardianship. One of these must be made by a medical professional who has specialised training and expertise in diagnosing and treating mental health disorders (e.g. a psychiatrist).

Section 136: Section 136 of the Mental Health Act 1983 gives police officers the emergency power to remove a person from a public place to a place of safety if they appear to be suffering from a mental disorder and need immediate care or control

SDEC: Same Day Emergency Care Centre

TES: Temporary Escalation Spaces

TRFT: The Rotherham NHS Foundation Trust

UCR: Urgent Community Response

YAS: Yorkshire Ambulance Service